SCHOOL AGE CHILD CARE PROGRAM REGISTRATION FORM

FALL 22-23

All children thrive and experience a future without limits.	DATE FORM RECEIVED________________ *Site Director Use Only*	REGISTRATION FORM PROCESSED ☐ REGISTRATION FEE ASSESSED ☐ SIGN IN/OUT SHEET ☐ ATTENDANCE LOG ☐

A $20 non-refundable fall registration fee (per child) will be billed to your child's account upon submission of this form.

CHILD TO BE ENROLLED (Use one form for each child) **SCHOOL:**________________________________

________________ ________________ ________________ ________

Last Name **First Name** **Teacher** **Grade**

School Attended During 2021-2022 School Year:____________________ **Child's DOB:**____________

List any siblings enrolled in the program:____

Name of Mother		**Home #**	
Address		**Cell #**	
City/State/Zip		**Other #**	
Employer		**Work #**	
E-Mail		**Work Hours**	________ to ________
Name of Father		**Home #**	
Address		**Cell #**	
City/State/Zip		**Other #**	
Employer		**Work #**	
E-Mail		**Work Hours**	________ to ________

If parents are divorced, which parent is the custodial parent? ________________________________

Is there a restraining order preventing one parent from having access to the child(ren)? Yes ____ No ____
If yes, a copy of the order must be on file with the SACC Program for compliance.

List person(s) and phone numbers to whom your child MAY BE released to or contacted if you cannot be reached (excluding guardian/parents):

1. ________________________________ Phone________________________
2. ________________________________ Phone________________________
3. ________________________________ Phone________________________
4. ________________________________ Phone________________________
5. ________________________________ Phone________________________

INSURANCE

HCDE does not provide accident insurance coverage for participants. All children in the program are encouraged to have medical insurance in case of an accident.

PLEASE COMPLETE THE BACK OF THIS FORM

EMERGENCY INFORMATION

Name of person, other than parent, authorized to act for parent in an emergency:

____

Address: ______________________ **Home Phone:** ________________________

Where Employed: __________________ **Work Hours:** ______________________

HEALTH INFORMATION

Child's health is: Excellent ____ Good ____ Fair ____ Poor ____

Does your child have a disability that may require assistance or accommodations? Yes ____ No____

Please explain: ____

If accommodations are needed, a supervisor will notify you to schedule a meeting before your child attends.

Other medical conditions/medications required: ____

Does your child have allergies (including bee stings)? ____________________________________

Name of child's physician: _____________________ **Office Phone:** ______________________

Hospital preference (In case of emergency): ____

I give permission for SACC to obtain medical treatment and procedures as may be appropriate in an emergency circumstance including treatment by a physician, hospital, and other appropriate health care provider, when and if parents, guardian or emergency contacts do not respond.

Signature of Parent/Guardian____

SACC Rates: $6 AM Care $9 PM Care $10 Half Day Care $20 Full Day Care
Half price sibling discount applies on above rates if all children attend on the same day.
Make checks payable to the Hamilton County Schools. Please write your child's name on all checks.
You can also pay by cash, debit card and credit card at each of the child care sites or online at https://sacc.hcde.org/
A convenience fee of $3.00 will be charged on each credit/debit card or online transaction.

Please sign below acknowledging the following:

1. **Child's immunizations are up-to-date and are on file at the school listed on the front of this form.**
2. **A copy of the SACC Parent Manual and Summary of Licensing Requirements is available online at www.hcde.org/SACC**
3. **I understand that by registering the child named above, I am assuming responsibility for all fees due for child care services.**
4. **I understand there will be a $10 late payment fee applied to my child's account if weekly fees are not pre-paid on Monday or the first day of attendance for the current week.**
5. **I understand that failure to make weekly fee payments will result in the child(ren)'s dismissal from the School Age Child Care Program.**
6. **I understand that the program closes promptly at 6:00 P.M. I understand that I am responsible for a late pick-up fee. If you arrive after 6:00 PM, you will be charged an additional fee of $5 for each 15 minutes per child or a portion thereof. If you arrive after 6:15 PM, you will be charged an additional fee of $1 per minute per child. I also understand continued late pick-ups could result in dismissal from the program.**
7. **A full legible signature with the time is required when signing a child in/out of the program.**

Signature of Parent/Guardian___________________________________

I grant permission for my child to be shown and/or identified in a film, videotape or photograph made by, or for the HCDE while participating in the School Age Child Care Program.

Signature of Parent/Guardian___________________________________